Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MEMORIAL HERMANN HOSPITAL SYSTEM
3200 SW FREEWAY SUITE 2200
HOUSTON TX 77027

Respondent Name

EMPLOYERS INSURANCE CO OF WAUSAU

Carrier's Austin Representative Box

Box Number 01

MFDR Tracking Number

M4-07-1596-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has not and cannot demonstrate that a reduction of total charges by over 58% constitutes a fair and reasonable rate of reimbursement, especially for treatment of this severely injured patient with an extended length of stay of 31 days." "Due to the nature of the patient's injuries, he required emergency services and supplies during his stay, including surgical interventions. The hospital billed its usual and customary charges in the total amount of $233,768.75…Requestor submits that a fair and reasonable rate for treatment of this injured employee is the usual and customary charges incurred since the carrier refuses to conduct an audit to refute those charges. Requestor is owed an additional $137,284.05, plus interest."

Amount in Dispute: $137,284.05

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary:

"Rationale for denial of 11 days:

TDI/DWC Rule 134.600 (p) states preauthorization is required for all non emergent inpatient admissions and all continued inpatient stays.

The claimant was admitted on 10/22/05 and discharged on 11/22/05. He remained in the facility for 31 days total.

The first 20 days were authorized under Pre-auth # 053080297L001001.

Liberty Mutual has no record of the hospital calling for preauthorization for continued stay (extension of days).

The last 11 days of this admission, dos 11/11/05-11/22/05 were not authorized.

These last 11 days were denied x170, preauthorization was required but not requested per TWCC rule 134.600.

Line item audit by Liberty Mutual and CorVel Medcheck Select:

> The bill was then reviewed per Rule 133.301 and the fee schedule guidelines, which allow for line item audit. Reductions may reflect fair and reasonable pricing, denial of personal items, non-compensable services, and or services not normally billed.
>
> Additional reductions, based on usual and customary charges in the same geographic area as the provider have also been applied…

Payment was calculated as follows:

> Denied 11 days inpatient…as x170 Pre-auth required, but not requested…
>
> Pd TX w/c f/s @ 75% of audited billed charges as complications doc & implants priced in-house invoices.
>
> Charges $233,768.75 – denied charges of $8,305.00 (R&B) - $27,117.10 (charges for 11 days) – implants $8452.75 – CorVel reductions $65,818.80= $124075.10 paid @ 75% = $93056.33 + implants @ $3064.84 (cost plus 10%) = $96,121.17."

Response Submitted by: Liberty Mutual (Wausau), 2875 Browns Bridge Road, Gainesville, GA 30504

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
October 22, 2005 Through November 22, 2005	Inpatient Services	$137,284.05	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 effective March 14, 2004, 29 TexReg 2360, requires preauthorization and concurrent review for non-emergency inpatient hospital services.
3. 28 Texas Administrative Code §134.401(c)(5)(A), effective August 1, 1997, 22 *Texas Register* 6264, requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate.
4. 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
5. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
6. This request for medical fee dispute resolution was received by the Division on October 20, 2006. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on November 16, 2006 to send additional documentation relevant to the fee dispute as set forth in the rule.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of Benefits dated February 7, 2006

   - Z601-The charge exceeds usual and customary.
   - Z695-The charges for this hospitalization have been reduced based on the fee schedule allowance.
   - X170-Pre-authorization was required, but not requested for this service per TWCC Rule 134.600.
   - U301-This item was previously submitted and reviewed with notification of decision issued to payor/provider. (Duplicate Invoice)

- Z560-The charge for this procedure exceeds the fee schedule or usual and customary allowance.
- X267-According to fee schedule guidelines, certification must be obtained for additional inpatient days beyond those initially precertified. There is no record of additional days being requested/certified, therefore payment is denied.
- Z652-No code description given.
- W1- Workers Compensation State Fee Schedule Adjustment.
- W10-No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology.
- 62- Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.
- 18- Duplicate claim/service.

Explanation of Benefits dated July 22, 2006

- Z601-The charge exceeds usual and customary.
- Z695-The charges for this hospitalization have been reduced based on the fee schedule allowance.
- X170-Pre-authorization was required, but not requested for this service per TWCC Rule 134.600.
- U301-This item was previously submitted and reviewed with notification of decision issued to payor/provider. (Duplicate Invoice)
- Z560-The charge for this procedure exceeds the fee schedule or usual and customary allowance.
- X267-According to fee schedule guidelines, certification must be obtained for additional inpatient days beyond those initially precertified. There is no record of additional days being requested/certified, therefore payment is denied.
- X598-Claim has been re-evaluated based on additional documentation submitted; no additional payment due.
- Z989-The amount paid previously was less than is due. The current recommended amount is the result of supplemental payment.
- Z652-No code description given.
- W1- Workers Compensation State Fee Schedule Adjustment.
- W10-No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology.
- 62- Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.
- 18- Duplicate claim/service.

Explanation of Benefits dated October 30, 2006

- Z601-The charge exceeds usual and customary.
- Z695-The charges for this hospitalization have been reduced based on the fee schedule allowance.
- X170-Pre-authorization was required, but not requested for this service per TWCC Rule 134.600.
- U301-This item was previously submitted and reviewed with notification of decision issued to payor/provider. (Duplicate Invoice)
- Z560-The charge for this procedure exceeds the fee schedule or usual and customary allowance.
- X267-According to fee schedule guidelines, certification must be obtained for additional inpatient days beyond those initially precertified. There is no record of additional days being requested/certified, therefore payment is denied.
- X598-Claim has been re-evaluated based on additional documentation submitted; no additional payment due.
- Z989-The amount paid previously was less than is due. The current recommended amount is the result of supplemental payment.
- Z652-No code description given.
- W1- Workers Compensation State Fee Schedule Adjustment.
- W10-No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology.
- 62- Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.
- 18- Duplicate claim/service.

Findings

1. 28 Texas Administrative Code §133.307(g)(3)(B), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including "a copy of any pertinent medical records."

   On December 7, 2006, the Division submitted a Notice to the insurance carrier that the requestor had not submitted additional documentation relevant to this fee dispute in accordance with 28 Texas Administrative Code §133.307(g)(3).

   Review of the submitted documentation finds that the requestor has not provided copies of any medical records pertinent to the services in dispute. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(B).

2. The requestor billed $34,619.00 for dates of service November 11, 2005 through November 22, 2005. The respondent denied reimbursement for these dates of service based upon "X170-Pre-authorization was required, but not requested for this service per TWCC Rule 134.600", and "X267-According to fee schedule guidelines, certification must be obtained for additional inpatient days beyond those initially precertified. There is no record of additional days being requested/certified, therefore payment is denied."

   The respondent states in the position summary that "The first 20 days were authorized under Pre-auth # 053080297L001001…The last 11 days of this admission, dos 11/11/05-11/22/05 were not authorized."

   The requestor counters that "Due to the nature of the patient's injuries, he required emergency services and supplies during his stay, including surgical interventions."

   28 Texas Administrative Code §134.600 (b)(1)(A-C) states "The carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (h) or (i) of this section, only when the following situations occur: (A) an emergency, as defined in §133.1 of this title (relating to Definitions); (B) preauthorization of any health care listed in subsection (h) of this section was approved prior to providing the health care; (c) concurrent review of any health care listed in subsection (i) of this section was approved prior to providing the health care."

   28 Texas Administrative Code §133.1 (a)(7)(A) defines a medical emergency as "a medical emergency consists of the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health and/or bodily functions in serious jeopardy, and/or serious dysfunction of any body organ or part."

   The Division finds that for dates of service November 11, 2005 through November 22, 2005, the medical treatment is not considered a medical emergency because no medical documentation was submitted to support an "emergency" as defined in 28 Texas Administrative Code §133.1 (a)(7)(A).

3. 28 Texas Administrative Code §134.600 (i)(1) states "The health care requiring concurrent review for an extension for previously approved services includes (1) inpatient length of stay."

   The requestor did not submit documentation to support concurrent review approval was obtained for dates of service November 11, 2005 through November 22, 2005 in accordance with 28 Texas Administrative Code §134.600 (i)(1). Therefore, reimbursement cannot be recommended for these dates.

4. This dispute relates to inpatient services rendered from October 22, 2005 through November 10, 2005 provided in a hospital setting with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.401(c)(5)(A), which requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 821.11. The Division therefore determines that this inpatient admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).

5. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:

   - The requestor asks to be reimbursed the full amount of the billed charges in support of which the requestor states "Requestor submits that a fair and reasonable rate for treatment of this injured employee is the usual and customary charges."
   - The requestor billed $199,149.75 for dates of service October 22, 2005 through November 10, 2005. The respondent paid $96,484.70. The amount in dispute for these dates of service is $102,665.05.
   - The requestor did not discuss or explain how it determined that reimbursement of the entire amount billed would yield a fair and reasonable reimbursement.
   - The requestor did not provide documentation to demonstrate how it determined its usual and customary

charges for the disputed services.

- The Division has previously found that "hospital charges are not a valid indicator of a hospital's costs of providing services nor of what is being paid by other payors," as stated in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, 22 *Texas Register* 6276. It further states that "Alternative methods of reimbursement were considered… and rejected because they use hospital charges as their basis and allow the hospitals to affect their reimbursement by inflating their charges…" 22 *Texas Register* 6268-6269. Therefore, the use of a hospital's "usual and customary" charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.
- The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

		7/13/2012
Signature	Medical Fee Dispute Resolution Officer	Date
		7/13/2012
Signature	Health Care Business Management Director	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.